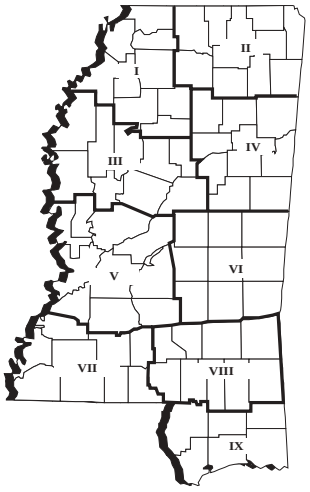
Responsibility And Services

Public Health Districts



The mission of state and local health agencies is to protect and promote the health of the citizens of Mississippi. Public health services are population-based — services focused on improving the health status of the population rather than the treatment of individuals. Federal public health agencies, the 50 state health departments, and the 3,000 local public health agencies nationwide share responsibility for this mission.

The Mississippi State Department of Health and other public health agencies nationwide balance three core government public health functions. These functions are essential to the maintenance of population-based services:

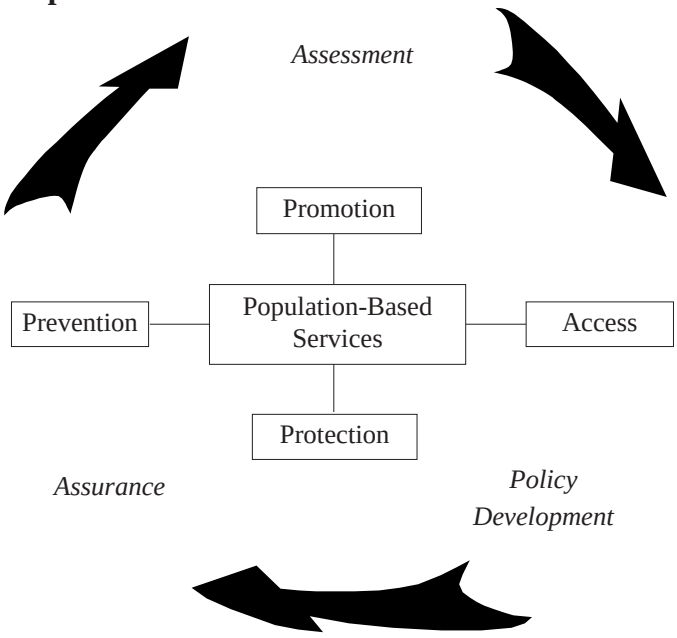
First, public health agencies assess community health status and whether the community has adequate resources to address the problems that are identified.

Second, they use the data gathered through assessment to develop health policy and recommend programs to carry out those health policies.

Finally, they assure that necessary, high-quality, effective services are available. This includes a responsibility for quality assurance through licensing and other mechanisms. Assure does not always mean provide. Rather, the government public health agency must see that services are somehow available to people who need them. Typical providers include private practitioners and non-profit agencies, including community health centers *and* government public health agencies.

The overall responsibility of the agency's central office is to provide program planning and policy guidance, along with administrative and technical support, to the staff in the districts and counties.

Population Based Services



Special Efforts In Public Health

■ **Nationwide Anthrax Scare Hits Close To Home In Mississippi —** September 11, 2001, marked the first time lives were lost on American soil since the bombing of Pearl Harbor during World War II, but also tested Mississippi's bioterrorism preparedness planning, readiness assessment, and potential response. The country's most visible attack and subsequent anthrax response charged public health officials with a challenge to protect Mississippians' health from the impact of potential subsequent attacks. The Mississippi State Department of Health spent tremendous human resources in preparation and in response to the anthrax scare that swept the nation after the September 11 attacks.

In the wake of terrorist attacks and the anthrax threats that unfolded in Washington and New York, Mississippians adopted a watchful attitude towards events they previously would not have questioned. The climate during this time dictated that each spill must be viewed with suspicion, whereas in former days, a dusting of white powder discovered on the counter in the employee break room would be presumed to be coffee creamer left behind by a hurried co-worker. The public paid closer attention to any and every white substance and mysterious powder found, powders which after tested by the State Public Health Laboratory turned out to be sugar, baby powder, soap flakes, and a number of inoffensive substances. Public health officials investigated each substance; the cost in terms of the Mississippi public health workers productivity is immeasurable.

Mississippi public health officials first felt the impact of the anthrax scare when the Public Health Laboratory became bombarded with numerous requests for testing of potential anthrax samples. The entrance of the laboratory was guarded; access into the facility was open to those who worked there or who had known privileged passes to get in the facility. The Association of State and Territorial Public Health Laboratories encouraged state public health laboratories nationwide not to disclose the location of their lab, so that terrorist could not find out where anthrax testing was taking place. When public health officials worked with the mass media in delivering news to the public about anthrax testing, public relations personnel and others asked the media not to disclose the Public Health Laboratory's location. Thanks to Centers for Disease Control and Prevention funding, the State Public Health Laboratory expanded testing capacity to BioSafety Lab 3 "hot lab" through the purchase of new equipment and supplies. The Mississippi State Department of Health had already spent grant funds and tremendous human resources in preparation.

Fears about deadly contaminations inflicted by terrorists upon whole populations were widespread after September 11. In Mississippi, those fears hit close to home in October 2001 when the crew of a towboat plying the Mississippi River near Rosedale reported being sprayed by a low-flying plane with a light white substance; the report prompted public health officials to investigate the incident. Both the FBI and Mississippi State Department of Health were called in to investigate; the Department of Health was to ascertain the nature of the substance. The crew was treated with Cipro, an antibiotic effective against anthrax, and quarantined for sixty hours, as a precautionary measure. Health officials ruled out anthrax and also ruled out the common farm applicators sodium chlorate and paraquat in final tests.

Health officials received another report of possible anthrax spraying on October 22, 2000; another plane sprayed a Coast Guard post in Natchez, 170 miles south of Rosedale. Authorities said the white powder released by a crop-dusting plane over a Coast Guard post on the Mississippi River was fertilizer. None of the four Guardsmen present at the station had shown any adverse health effects.

Investigators in this case found that the substance apparently was in the air before the plane flew over the area and was consistent with material often emitted by a nearby paper processing plant.

In the end, state officials said they considered the Rosedale incident with the towboat as an unlikely terrorism target and pointed out that accidental flyovers are common with crop dusters – 147 were reported in 2000. But the response to the Coast Guard report warranted attention because they are a branch of military and a likely terrorist target.

During the time of the anthrax threat in Mississippi, state public health officials partnered with other state agencies to respond to an influx of press calls about the alleged anthrax spraying incidents. Daily, health officials would conduct press briefings through an audio news conference in which local, national, and international media would call in to get continuing coverage of possible bioterrorism threats in Mississippi. Local media provided more in-depth coverage as the anthrax threats unraveled, but continued to diligently deliver continual public health news to their audience regarding bioterrorism. The daily press briefings allowed State Health Officer Dr. Ed Thompson an opportunity to deliver reports of anthrax testing results — an item local media inquired about daily. After the anthrax threats began to calm down, Mississippi news media still reported on bioterrorism in delivering basic public health messages about the public health topic.

- **Trauma Designations Across Mississippi —** The Mississippi State Department of Health designated several Mississippi hospitals as trauma center designations through the Emergency Medical Services Division (EMS) during FY 2002. Under Mississippi law, hospital emergency departments can seek designation as a Level I, II, III, or IV trauma center, with Level I requiring the most resources. All trauma centers participate within the Mississippi Trauma Care System to ensure trauma patients get the right care at the right place in the right amount of time.

  The designations set specific criteria and standards of care that guide hospital and emergency personnel in determining the level of care a trauma victim needs and whether that hospital can care for the patient or should transfer the individual to a trauma center that can give more specialized care. State surveyors inspect each hospital to critique the type of care delivered to trauma patients, how that care is delivered, and what hospital could do to improve its delivery. Areas evaluated as part of the process include administration, anesthesiology, clinical laboratory, critical care units, emergency department, patient transfer agreements with other hospitals, pre-hospital services, quality improvement programs, radiology, and surgery services. In addition to the medical services provided, trauma centers must also exhibit a commitment to community outreach.

  To qualify as a Level I trauma center, facilities must have a full range of trauma capabilities, including an emergency department, a full-service surgical suite, intensive care unit, and diagnostic imaging. Level I centers must have a residency program, ongoing research, and provide 24-hour trauma service in their facility. These hospitals provide a variety of other services to comprehensively care for both trauma patients, as well as medical patients. To be considered a Level II trauma center, facilities must be able to provide initial care to the severely injured patient. These facilities must have full range of trauma capabilities, including an emergency department, a full service surgical suite, intensive care unit, and diagnostic imaging. For specialty care, a patient may be transferred to a Level I trauma center.

As a Level III trauma center, a hospital must commit medical staff, personnel, and speciality training needed to resuscitate and stabilize a trauma patient. Operating rooms are required since some people need surgery before possible referral to a higher level of care. In many cases, patients can get medical needs attended and remain at the Level III trauma center. As a Level IV trauma center, a hospital is able to provide initial care to the severely injured despite limited resources, often serving the most remote areas of the state or region. Level IV centers initially stabilize patients and then transfer, as needed by prearranged agreements. Trauma patients with minor injuries can receive appropriate care at the Level IV facilities.

The Mississippi State Department of Health's Division of Emergency Medical Services leads the development of the statewide trauma care system. They also provide technical assistance to hospitals going through the process to develop a trauma center. The State Health Officer designated seven trauma care regions for the planning of the Mississippi Trauma Care System. Each region has a representative on the Mississippi Trauma Advisory Committee, which was appointed by the Governor in FY 1999. This committee continues to meet periodically, developing the Mississippi Trauma Care System.

Forrest General in Hattiesburg became the first fully designated Level II trauma center during FY 2002, a first for the state's Trauma Care System. The State Health Officer gave recognition to hospitals throughout the state which have met the Trauma Care System's definition as a provisional trauma care center. Forrest General was provisionally designated two years ago as a Level II, but subsequently strengthened areas of their program that were identified in their previous inspection report. An inspection team reviewed the Hattiesburg facility April 2002 and recommended full designation; the Mississippi Trauma Advisory Council concurred, and the State Health Officer designated the facility.

- **Mississippi Tuberculosis Rate Lowest Than National Average For First Time in Three Decades —** Mississippi made public health history: for the first time in three decades, Mississippi's tuberculosis (TB) case rate was lower than the national average. National and state TB statistics for 2001 show that for the first time in 32 years — since 1969 — the state's case rate fell below the nation's case rate. Mississippi's 2001 TB case rate is 5.4 per 100,000 population. The nation's 2001 case rate is 5.6 per 100,000.

  In the early 1980's, Mississippi ranked second highest in the nation for TB. Mississippi's TB case rate has fallen every year for the past 12 years but had stubbornly remained above the national average. Public health officials credit aggressive tuberculosis control efforts by public health nurses and other public health staff who have actively delivered therapy — directly observed therapy (DOT) and directly observed preventive therapy (DOPT) — and to private physicians who work with the Health Department. DOT is a multi-drug therapy for patients with active TB disease, which if not treated appropriately would result in greater transmission of the disease. Public health workers administer DOPT when a person is exposed to and infected with TB but does not show signs of active TB disease.

  In the 1900's, TB was one of the leading causes of death. Today tuberculosis is still one of the leading global causes of death from infectious disease, even though TB is readily preventable and treatable. Mississippi still has pockets of TB, and state public health officials are working actively with the Centers for Disease Control and Prevention (CDC) to identify and reduce risk factors.

Report Of Activities

Fiscal Year 2002
Report of Activities
by Program

Community Health Services

AIDS cases reported 362
Diabetes patients served 150
Diabetic monitoring visits 557
Hypertensive treatment visits 6,836

Personal Health Services

■ **Child Health**

Children (ages 1-21) served 76,710
Genetic counseling patients served 1,550
Newborns screened for phenylketonuria, hypothyroidism, galactosemia, and hemoglobinopathies 44,008
Children's Medical Program
Clinic sessions per year 650

■ **Home Health**

Patients served 2,013
Registered nurse visits 39,512
Other visits 92,338

■ **WIC - Special Supplemental Nutrition Program for Women, Infants, and Children** *(Average monthly participation)*

Women 23,725
Infants 31,645
Children 42,276

■ **Women's Health**

Pregnant women served 11,500
High-risk mothers and infants served through PHRM 27,413

■ **Reproductive Health**

Adult patients served 58,000
Teens served 28,000

Health Regulation

■ **Environmental Health**

Environmental samples collected and analyzed for radioactivity 1,308
Radon in indoor air evaluations and/or screenings 847
Boilers and pressure vessels inspected 10,767
Food establishments permitted 11,787
Inspections of food establishments 29,288
General sanitation complaints investigated 4,203
Sewage disposal inspections and soil/site evaluations 74,619
Dairy farm inspections 1,854
Milk plant inspections 22
Milk samples analyzed 4,619
Environmental lead risk assessments 94
Community public water supplies surveyed 1,477

Health Regulation *(continued)*

■ Licensure

Ambulance permits issued 529
Emergency medical technicians certified/recertified 3,277
EMS drivers certified/recertified 3,382
Emergency services licensed/relicensed 133
Health facilities surveyed 951
Health facility complaints investigated 404
Youth camp inspections 34
Child residential care homes monitored per Notification Act 12
Day care facilities inspected and licensed 1,818
Day care complaints investigated 429
Licenses issued for athletic trainers, audiologists, hearing aid specialists, occupational therapists and occupational therapy assistants, physical therapists and physical therapy assistants, radiation technologists, respiratory care practitioners, speech-language pathologists, tattoo artists, AA Therapists, and body piercers 8,519
Registered or certified audiology aides, eye enucleators and speech-language pathology aides 48

■ Planning and Resource Development

Declaratory rulings issued 450
Certificate of Need applications reviewed 74

■ Health Facilities *(Licensed or Certified)*

Hospitals-accredited 65
Hospitals-non-accredited 48
Nursing facilities 200
Home health agencies 65
Intermediate care facilities for the mentally retarded 13
Personal care homes 203
Hospices 51
Ambulatory surgical facilities (only 20 licensed) 37
Community mental health centers 5
Rural health clinics 134
End stage renal disease facilities 62
Comprehensive outpatient rehabilitation facilities 19
Rehabilitation agencies 47
Abortion facilities 2
Utilization review agents 131
Laboratories - CLIA surveys 1,851

Fiscal Affairs

Actual Expenditures by Program

	FY 2002	FY 2001	FY 2000
Chronic Illness	8,766,198	9,730,865	9,859,567
Community Health	36,640,145	39,137,884	35,316,334
Environmental Health	13,055,566	13,848,204	12,786,363
Licensure & Resource Dev.	21,482,587	20,585,664	21,154,574
Maternal & Child Health	109,177,471	103,577,437	107,750,130
Support Services	14,664,832	13,992,745	13,146,054
Total	**$203,786,799**	**$200,872,799**	**$200,013,022**

Figure 4
2002 Expenditures by Category

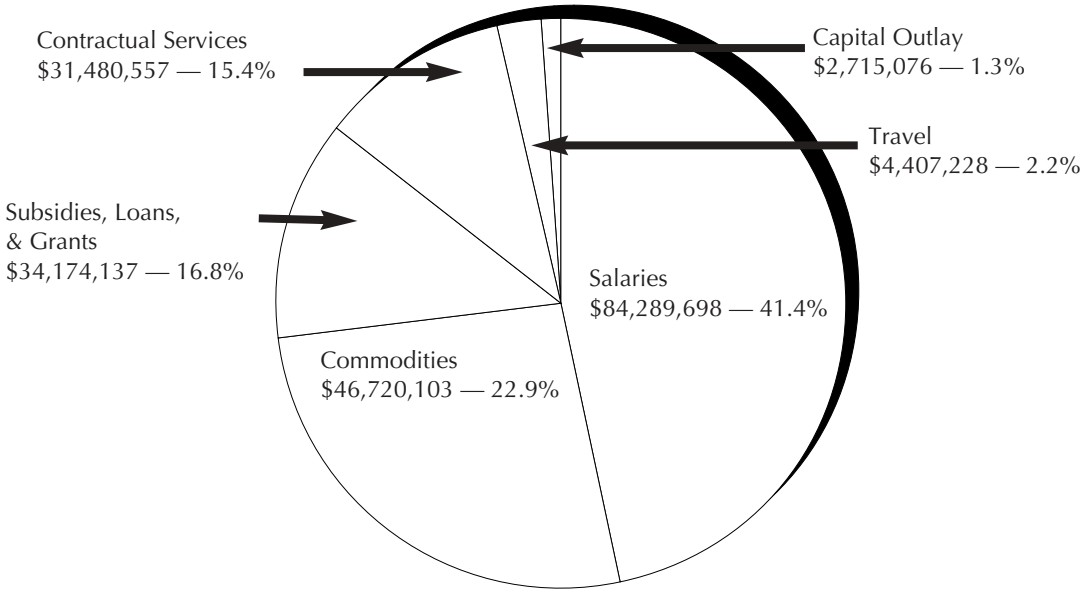
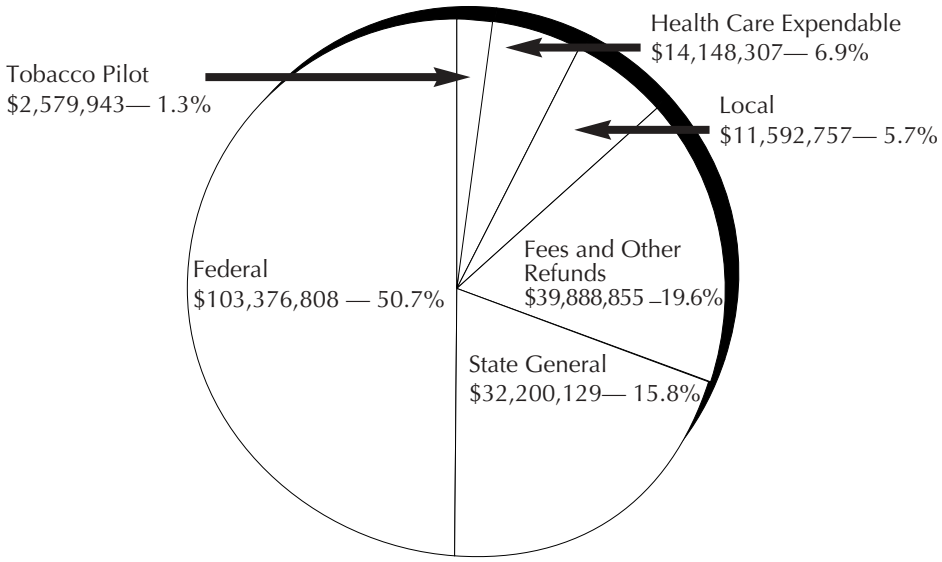


Figure 5
2002 Expenditures by Fund



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MISSISSIPPI STATE DEPARTMENT OF HEALTH
Communications and Public Relations
Post Office Box 1700
Jackson, Mississippi 39215-1700 *Published 2002*

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